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WORLD HEALTH

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47TH YEAR, NO. 6, NOVEMBER–DECEMBER 1994

REACHING OUT TO THE POOREST

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Editorial

Growing inequity is a matter of life and death

Hiroshi Nakajima

Dr Hiroshi Nakajima, Director-General of WHO.

How will history judge the 20th century? Will it be seen as the era of mankind's greatest advances in science, technology and economic productivity or as the era when human development faltered and gave rise to a wave of poverty like some epidemic of medieval times? As the century draws to a close, I fear that it is the latter image which future generations will hold, unless we take decisive action. The tremendous gains made in health development in the past three decades are at risk because the increasing gaps between rich and poor pose an unprecedented challenge to the health and well-being of the peoples of the world.

Emphasis in development has for too long been on economic advancement alone, based on a simplistic belief that an increase in national income would, of itself, result in social improvements including health. In effect the world has reverted to a latter-day trickle-down theory of development, an approach that was already discredited 30 years ago. Furthermore, the promise of more money for social development, following the end of the Cold War, has not materialized.

As usual, the poorest countries have been hit hardest. The number of so-called Least Developed Countries has risen to 47 in the last two years. In many industrialized countries too, poverty is an increasing issue, hidden behind a veneer of overall prosperity.

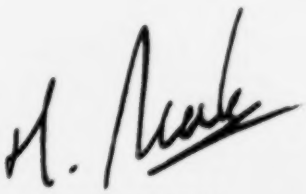
For WHO, growing inequity is literally a matter of life and death, since the poor pay the price of social inequality with their health. Recent evidence from some industrialized countries shows that a widening income gap between the rich and poor is accompanied by increasing differences in mortality. On the other hand, life expectancy has increased most rapidly in those developed countries where income differences have narrowed. In other words it is the equity gap which counts.

Improving the health of nations is therefore dependent on reducing inequities both between countries and between the rich and poor within a country.

The basic elements of our strategy for action are:

- Ensuring that the poorest and most vulnerable groups of the population have access to primary health care. This means redirecting often scarce money as well as personnel to the frontline of the health care system at community and district levels. It also means increasing their access to information about health.
- Protecting the poorest from risks to health which are beyond their control: protection from environmental hazards; protection from crime and violence; access to adequate food, shelter, water and sanitation; and, above all, the ability to earn an income. These are the basic minimum needs for health and development.
- Building strong commitment to health among top political leaders in all countries. This includes assuming responsibility, at the highest level, for monitoring the reduction of health inequities.

We cannot pretend that the task is easy. The articles in this issue of *World Health* testify to the progress achieved and the difficulties that lie ahead. We all must learn from these experiences and use that knowledge to strengthen and extend action to the benefit of more and more people. In my opinion the principle of our support must be to work *with* the poorest people and countries and not just *for* them. ■



Hiroshi Nakajima, M.D., Ph.D.

Reaching out to the poorest

Mother and child in Guinea-Bissau. Improved health management is increasing the population's chances of staying healthy.

Recent years have seen a marked improvement in the health of a majority of people in most countries of the world, yet huge numbers of the poorest people still have little or no access to health care. This is largely due to the worsening health situation in the poorest countries, where the gap between the rich and the poor is wider than ever. The vicious circle of poverty, ignorance and ill-health is one which poor communities find impossible to break.

Today, some 2000 million people throughout the world live in poverty, and 700 million of these live in *extreme* poverty, which means suffering from malnutrition, poor health, and exposure to multiple diseases – mostly caused by insanitary conditions and lack of clean water – and a life-expectancy of only 50 years.

Growing poverty and its consequences on health are an affront to the main social target of governments and of WHO. So, in 1977 it was decided that all peoples of the world should, by the year 2000, attain a level of health that will permit them to lead a socially and economically productive life. In 1988, and as a consequence of the major obstacles encountered in health development, the initiative to intensify WHO cooperation (IWC) with countries and peoples in greatest need was launched.

This initiative will enable countries to establish and maintain equitable and sustainable health systems, tailored to their needs. Requests for intensified cooperation have been received from the governments of 26 countries, where activities have been initiated following situation assessments and the development of plans of action based on priority needs. Additional resources are mobilized through coordinated donor efforts.

WHO does not play a traditional donor role – rather it establishes a collective partnership with a country, encouraging national authorities to manage their resources more effectively. It also seeks to mobilize additional external donor participation in such a way as to reach those communities in greatest need.

The countries currently participating in the initiative are: Bangladesh, Benin, Bhutan, Bolivia, Burkina Faso, Cambodia, Cape Verde, Central African Republic, Chad, Ethiopia, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Lao People's Democratic Republic, Maldives, Mongolia, Mozambique, Myanmar, Nepal, Sierra Leone, Uganda, Viet Nam, Yemen and Zambia.

One of the first countries to join the initiative was *Nepal*, a country where the poorest were not reached by the health services and only one-third of the population had access to health care. Its priority needs are the rational planning of human resources, the strengthening of district health systems, and the improvement of local capacity to plan and manage the financial aspects of the health services. With the support of this initiative, Nepal is seeking ways to overcome its difficulties and develop better aid coordination and management.

Guinea Bissau, in collaboration with WHO, is also seeking to improve health management through a new management structure leading to better regional health services. In spite of scarce available resources, high motivation and regular meetings have led to visible improvements in primary health care, continuing education of health workers, and a more efficient supply of drugs. National statistics show that immunization coverage in those regions benefiting from the new management structure have significantly increased due to these improvements.

The health authorities in *Cambodia* have, with the assistance of WHO, improved their capacity to plan and reorganize the country's devastated health services, by better coordinating the work of voluntary organizations, and planning more effectively the use of resources.

We look forward to being able to share other such successful experiences from other countries in greatest need. ■

Contributed by the Division of Intensified Cooperation with Countries, World Health Organization, 1211 Geneva 27, Switzerland.

A health insurance scheme for Zaire

N. Sema Hurugo

Safe water in the village. Rural families in one district of Zaire are now covered by a health insurance scheme.

A health insurance society has been in existence in Zaire since 1986. It was started by the Bwamanda Centre for Integrated Development to counter the difficulties which the district's rural population faced in having no fixed income to pay for hospital care, and also to compensate for reduced external financing.

Membership of the Mutual Society, a true health insurance scheme, is not obligatory. So people have to be made aware of its value and convinced that sickness is a risk inherent in life which they must make provision for so that, when it does occur, they are prepared against the unforeseeable aspects – its gravity, duration, overall cost and economic consequences, and the professional and moral impact.

The registering of new members takes place in March each year, the period when both the Centre for Integrated Development and the traders are engaged in buying agricultural produce. The peasants therefore have some income and can afford the annual premium. This premium takes account of local purchasing power, and is fixed empirically at a sum equivalent to the price of two to three kilograms of soya per year and per individual.

When an individual signs up with the Society, he or she is also obliged to sign up all the family members, each paying an individual premium. So members are in family units and today include 60% of the population of Bwamanda.

Family files

The health centres maintain files on each family and it is they who refer the sick to hospital, with a transfer coupon affirming that they are Mutual Society members. The Society covers all their hospital care and some primary care dispensed at the health centres, particularly for tuberculosis, heart diseases, leprosy and childbirth.

The success of Bwamanda's Mutual Society is due principally to three factors:

- participation of the community and of the agencies of the medical service and of rural development in all stages of the process, from conception to organization;
- the trust existing between the community and the medical service, thanks especially to the quality of health care offered and to such other activities of the Centre for Integrated Development as farming, digging of wells and rural promotion drives;
- the investment of the funds collected in the purchase of drugs. The existence of a well-run regional pharmacy helps to ensure that the contributions collected are well spent.

Fully accepted and understood by the people of Bwamanda, the Society has already shown good results. It gives people greater access to health care by covering 80% of all outpatient and hospital treatment. It has much improved the finances of the general referral hospital by ensuring that 70% of the costs are recouped, a remarkable feat considering the social and economic crisis at present facing Zaire. Finally, by encouraging those who are well to pay for those who are sick, it represents a real attempt to promote community solidarity. ■

Dr N. Sema Hurugo is Medical Director of the Centre for Integrated Development, Bwamanda, B.P. 11, Gemena, Zaire.

A strategy against poverty

W. A. Hassouna

The aim should be to put "reasonable quality of care" at an affordable cost within the reach of the poor, rather than offering low quality of care at cheaper prices.

Queuing at a health centre in Lesotho. Access to health care is a key escape route from poverty.

Everybody's treatment-seeking behaviour is influenced by several factors which include their level of health awareness and their perception of disease, sickness and health as well as their accessibility to health services. Access to health services in turn is affected by several factors, such as:

- the physical distance or travel time between the patient's home and the health providers;
- the social acceptability of the services to the patient, which includes attitudes, behaviour and gender of the service providers;
- the patient's perception of the appropriateness or effectiveness of services in relation to their health condition – namely, quality of care;
- the patient's ability to pay for the required services – namely, the cost of care.

Among these factors, the cost of health services seems to be the most crucial variable affecting the patient's decision to use or not use the service. This includes both the direct cost which the person pays to the service provider, and indirect costs which the patient is obliged to bear, such as travel time and cost of transport, deductions from salaries or wages, or payment to a baby-sitter for tending the children during the patient's absence from home.

It is evident that people tend to use less costly services, i.e. those within their economic means, especially when they feel their needs are being satisfied. On the other hand, some people may be willing to go beyond their economic means to pay for health services when they perceive this is necessary to avoid intolerable pain, severe disability or threatening death. They may borrow money or sell some of their assets or even take illegal measures to pay for costly health services. Others may delay their use of health services or may not use them at all because they are beyond their economic means, while rationalizing their behaviour in various ways. Or they may resort to consulting neighbours, friends, family members or quacks to avoid paying the high cost of health services. It is commonplace for people to turn to pharmacists in order to avoid paying physicians' fees.

Promoting access

In these circumstances, it is obvious that promoting free or low-cost access to health services is one of the crucial strategies which could enable the poor to use the resulting savings to satisfy other vital needs like food, clothing, heating and so on. Poor people spend a sizeable percentage of their disposable income on health services; the proportion varies between 15% and 20% and is usually less than half what they spend on food consumption.

So increasing people's accessibility to health services – within their ability to pay – could positively change their treatment-seeking behaviour. They would resort earlier to health services and hence benefit from early detection, diagnosis and treatment. This would subsequently enable them to save expenditure on chronic or complicated cases. It is worth noting here that women and children are more affected by poor accessibility to health services, and this situation is more common in the countryside than in the cities.

In most developing and some developed countries, governments have been the major providers of preventive and curative health care. These services used to be accessible to the poor since they were provided without charge. But the unpreceden-

ted escalation of the cost of health services in the last ten years and the adoption of economic reforms which usually resulted in sizeable reductions of allocations for health services have greatly reduced the access of the poor to government health services. Such reforms have affected curative more than preventive care since many governments provide the latter free or at minimal cost.

Immunization for a child in Jamaica: it costs nothing – and may save a life!

NGOs and the private sector

As a result of the reduced role of the government as health provider, the private sector and nongovernmental organizations (NGOs) have started to contribute a bigger share to the health services. The fact that the private sector is profit-oriented tends to put such services far beyond the poor people's ability to pay. This leaves the NGOs with an increased responsibility for providing health services, mainly to the poor.

The ways in which NGOs can increase access to health services, especially for the poor, include:

- bringing services – particularly primary health care – closer to the people;
- charging very low fees for services;
- providing a simple mechanism for group health insurance with reasonably low overheads.

In some countries, NGOs – which frequently have religious affiliations and are socially acceptable – have proved to be very effective in increasing the accessibility of health services to the poor.

A nurse in India checks on a child's nutritional status by measuring the circumference of the arm. Cost should not deter poor people from attending primary health care services.

Several ways have been adopted in various countries to increase access to health services, all of which are aimed at reducing the patient's economic burden. Unfortunately, most of the approaches such as health insurance and cost-sharing are geared to helping middle-income groups rather than the poor who cannot afford to pay insurance premiums or even reduced fees, and in many cases will not have the cash to pay for health services when they are seriously sick.

It seems clear that what is needed is a system that ensures for the poor a reasonable access to health services with a minimal economic burden. This could be done by including specific health benefits within a compulsory social insurance system or making available interest-free loans from group savings to be used in case of sickness.

Certainly, increasing access to health services as a strategy for poverty alleviation should be dealt with in a comprehensive manner that takes into account physical, social, cultural and economic factors. The ultimate aim should be to put "reasonable quality of care" at an affordable cost within the reach of the poor, rather than offering low quality of care at cheaper prices. ■

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Basic minimum needs in the Eastern Mediterranean

The Eastern Mediterranean Region of WHO is promoting the basic minimum needs (BMN) approach in the Region as an innovative means of ensuring equity in health care, a better quality of life and new hope for disadvantaged communities. This approach is based on self-reliance and community participation, with WHO acting as a catalyst, essentially leaving it to each community to rectify potentially unhealthy situations.

Imposing "correct" answers to problems or simply supplying a drainage system, for example, may have only a short-term beneficial effect. Unless villagers are themselves involved in working out solutions and putting them into practice, they neither believe in nor respect such outside aid. They have no incentive to maintain or even to use the facilities.

Under the BMN approach, a village community may first be invited to participate. Then WHO staff may prepare a questionnaire asking about family size, the sources of drinking-water and so forth. A set of general goals may be suggested: perhaps that every person should be no more than half-hour's walk from drinkable water, or that children's growth should be monitored to ensure their adequate nutrition. The village then decides on which priority it wishes to spend its money and time. The aim is to improve many aspects of village life a little, rather than transforming any given sector completely. Where necessary, WHO offers five-year, interest-free loans to village cooperatives for schemes which may include starting a village health centre, promoting cash crops, or even encouraging bee-keeping.

Poverty, violence and health

Johan Galtung

Tremendous ingenuity is dedicated to finding curative therapies for cancers, heart attacks and strokes. But these are not the health problems of the miserable of the world. The problem is not poverty as such, but the power of the affluent to tilt the use of the world's resources in their favour.

In many poor societies, people never manage to escape from the vicious circle of poverty and ill-health.

At one level of thinking it is all so simple. In many parts of the world, many people – perhaps most people – are poor; sooner or later that fact shows up because poverty takes its toll. Poor people cannot afford preventive or curative medical services in countries that do not guarantee health for all; so they not only fall ill (we all do from time to time), but they never manage to get out of their ill-state and into a well-state. Illness becomes multiple and chronic.

For all kinds of reasons, the poor resort to violence to try to improve their condition, trying to shake off the people or institutions they think are riding on their back. However, violence tends to hit back at the violator and ill-health spreads, at times respecting nobody, as in total war. Even worse: in post-modern wars, the military no longer fight each other – that would be too risky – but turn against the civilian population. During the First World War, 10% of those killed were civilians. Since the end of the Second World War, 90% of those killed as a result of war in developing countries were civilians. The health implications are obvious. Moreover there seems to be street violence all over the world today, and guns are used to settle trifling conflicts.

Social conflicts can end up in street violence.

So, poverty leads to ill-health and may lead to violence, and violence always leads to ill-health. Conclusion: abolish poverty and we can get rid of poverty-induced diseases; get rid of some types of violence and we shall all be better off!

Not so simple

Unfortunately, reality is not that simple. As a first step let us make a distinction between *poverty*, meaning having little, and *misery*, meaning having so little that it hurts and harms, or having the wrong things that may distort the body, mind and spirit.

Young students are usually poor, but that does not mean they suffer from ill-health. Their plight, if that is the word, is something temporary and has been voluntarily entered into. Basic to misery is that it is neither wanted nor temporary. Moreover, it is a vicious circle – too little and inadequate food, polluted water and air, noise, lack of sleep – a violent environment breeding suspicion and violence. Conditions such as these do not only lead to ill-health; they

War destroyed her parents' home. Modern warfare hits hardest at civilians.

amount in themselves to the lack of social well-being referred to in WHO's definition of health.

"Neither-too-much-nor-too-little" is a good formula, but it is not the formula of today's society, where economists and others focus on economic growth rather than on economic adequacy. Striving for affluence beyond what the planet can carry and what society can afford means that the costs will have to be borne somewhere else. Namely, by the environment, by the poor, by the poor countries; and more particularly by the environment and the poor in poor countries. And this is where misery accumulates. Misery certainly kills, and so does affluence to the extent that it creates misery on its periphery. The diseases of affluence, such as malignant tumours and cardiovascular diseases, kill people in affluent societies and classes, or make their long lives miserable through mental disorders.

Somewhere there should be a golden mean here; keeping the values and many of the traditional and more human structures of society, yet utilizing basic medical knowledge for prolonging life without creating the tyranny of modern diseases of affluence. This is impossible under misery, and difficult with affluence. As it is, today's pursuit of happiness through economic growth and wealth makes us blind to this possibility.

Instead, medical resources tend to be channelled towards modern-day diseases, and tremendous ingenuity is dedicated to finding curative therapies for cancers, heart attacks and strokes. But in a world perspective these are the diseases of the affluent in all societies, not the health problems of the miserable of the world. The problem is not poverty as such, but the power of the affluent to tilt the use of the world's resources in their favour.

Something of the same holds true for violence. Interestingly, one of the few forms of violence that has been virtually eliminated in practice is the duel, possibly because it hit the ruling elite who duelled themselves to death in great numbers. At the same time incredible weapons of mass destruction – meaning extermination of the masses – are being developed all the time. And any effort by poor countries to acquire them is resisted with extreme belligerence, so as not to upset the control from the top.

In short, we need to train our eyes on the power structures of the world. They can be changed for the better, and some small countries have been able to do so. The problems may be most evident among the poor, but it is not they alone who hold the keys to change. We all do. ■

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Grinding poverty destroys all hope of enjoying normal social well-being.

Poverty, prostitution and women

Meena Poudel

There is a growing risk for Nepali girls of being sold to traffickers of women. Let us protect them.

The conditions are ripe in Nepal for a very serious AIDS epidemic, and for AIDS to become a women's disease. It has been said that by the year 2000 there will be more HIV-infected women than men in the world, but in Nepal this is already the case.

In economic terms women – representing half of the population – control only 20% of the world's property and goods. In Nepal, as elsewhere in developing countries, declining rural economies and environmental depletion have been undermining the position of rural women. Their activities are focused around the household, home-based industry and agriculture. While resources are being whittled away by the multinational companies, women's petty tradings are taken over by big business and the prices of basic commodities soar, wages decline, and – above all – their self-respect and self-esteem are crushed. Because of this, increasing numbers of women are being forced to become actively involved in the sex industry – mostly for survival or to get food for themselves and their family.

In Nepal, the trafficking in young girls is taking place faster than the public can imagine. While we have no firm, reliable data, it is estimated that about 200 000 Nepali girls and women are working as prostitutes in the brothels of India. Hundreds of Nepali men and women are working as traffickers and brothel operators; whole villages obtain a substantial income from selling off their own daughters, sisters and wives.

"I want to go back to the brothels to earn more money. I can get up to 5000 rupees per night!" says X when asked about why she wanted to go back. The desire for making money is strongly inculcated among many previously poverty-stricken women. Even within the country, women sex workers are found in Kathmandu and all of Nepal's main towns.

Spread of infection

Because of unemployment, poverty and the influences of "modernization", many young people are migrating from the countryside to the towns looking for jobs, often helped by the village agents. Most of them are destined to become cheap labour, working in carpet and garment factories and hotels. All too many girls are either brutally raped or trafficked abroad from these workplaces. From the far western and northern regions of Nepal, men travel to India during the slack farming season (winter) and work as porters or watchmen. While they are away from the family, they may visit cheap brothels and become infected with sexually transmitted diseases, then return home and infect their wives. There is no proper condom distribution system and the men usually don't have the mentality to use them. Even though wives may get infections from their husbands, it is the women who will be rejected

Countries where women are seen as a commodity that can be bought pay a heavy price in the spread of HIV.

from the family if they are identified as HIV-positive; men are never blamed for their mistakes.

"My family didn't want anything to do with me while I was helpless in police custody (for two years). It was not until nine years later, when I was making a good living and making money, that they were happy to accept me!" said Y, when she was asked about the importance of money influencing her family relationship.

The principal cause of the greater risk of HIV infection in Nepal is poverty. Where relative poverty levels are high and women lack alternative work opportunities, many are induced to turn to prostitution. Male/female differentials in income result from a combination of traditional and biological factors, the limited demand for work, and economic institutions that induce labour market stratification.

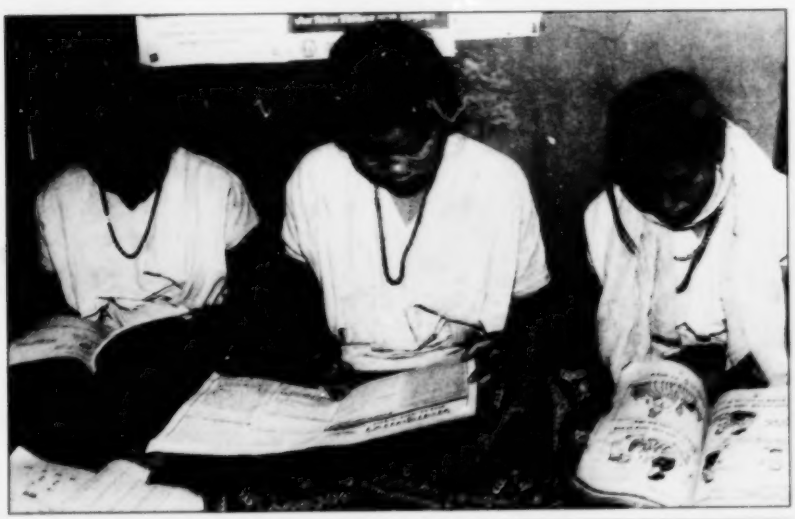
Paying a heavy price

Women's bodies, beauty and sex have become highly demanded commodities in this part of the world. Sex tourism, match-making, bride-supplying, pornography and so on are all the result of this thinking. Since buyers of these commodities can spend a lot of money, girls and women are very easily lured. Thailand, Philippines and Nepal are the countries where such businesses are prospering but these countries are also paying a heavy price: the spread and growth of HIV infection and AIDS.

The conditions are ripe in Nepal for a very serious AIDS epidemic, and for AIDS to become *a women's disease*. The epidemic is hitting all groups of people, not just certain subgroups. It has been said that by the year 2000 there will be more infected women than men in the world, but in Nepal this is already the case. The main reasons for this situation among women can be ascribed to widespread poverty, low status, lack of decision-making rights, lack of access to and time for education and information, rural–urban imbalances, inability to assert their rights, and so on. Government policies, services and awareness-raising activities are concentrating mainly on rural elites. *Empowerment of women has been limited to the conference rooms of five-star hotels*. The women of the countryside are being victimized because there are no other alternatives.

Here are some suggestions about actions that could be taken to address the problems:

- offer alternative survival opportunities to poor and disadvantaged women so that they are not forced into prostitution, with such consequences as HIV infection and AIDS;
- promote awareness among both women and men about HIV/AIDS, the risks of trafficking and preventive measures;
- organize poor and disadvantaged women from the lowest social levels around the whole issue of sexual discrimination, and encourage them to overcome the problem collectively;
- ensure the empowerment of women: socially, mentally and economically. ■



An adult female literacy class. Education is an essential tool for the empowerment of women.

Dr Meena Poudel chairs the non-profit-making Nepalese organization WATCH: Women Acting Together for Change, which offers support to poor and socially oppressed women, including those with HIV/AIDS. Its address is: GPO Box 5723, Kathmandu, Nepal.

Towards equity in Guatemala

Jacobo Finkelman

Children playing amid the garbage. Poor living conditions have far-reaching consequences for people's health.

Guatemala is a country which cries out for a more equitable health system. In spite of various efforts to improve living standards for all citizens, 75% of the population continue to be excluded from the benefits of development, according to the National Institute of Statistics, 1989. The extremely poor, in particular, exist on a subsistence economy in conditions of underemployment, with no access to markets and credit, belong mainly to monolingual Mayan ethnic groups, are illiterate, and live in scattered villages on the high plateau or in city slums, mainly in the capital.

The indigenous population constitute the largest and poorest group of the poor, 87% of them living below the extreme poverty line. In 65% of their homes there is no safe water supply and 75% have no electricity.

The low standard of living contributes to the high rates of infant mortality (while 54 per 1000 live births were reported as a national average, in Ixil, Department of Quiché, the rate for 1992 was 120.5), and of maternal mortality, with a national rate of 2.48 per 1000 live births.

Historically, the indigenous population has suffered a progressive decline in living standards as a result of policies relating to patterns of landholding, social and political inequity, and economic factors, which include more recently the effects of macroeconomic adjustment policies.

Although Guatemala is an essentially agricultural country, problems of land ownership still cause disputes, particularly because of the annual migration of some 800 000 people who move as families from the mountains to the coast for the coffee, sugar and cotton harvests, while the very poor are continually on the move to the cities or to colonize forest areas. As well as contributing to poverty, these patterns of landholding help to accentuate degradation of the environment. As new ground is broken for subsistence crops or big livestock projects, or as forest areas are cleared for firewood or large-scale commercial timber exploitation, there is depletion of natural resources as well as increased erosion and soil losses, bringing poverty in their wake. At the same time there is underuse of fertile lands on the large estates that produce crops for export.

In Guatemala, PAHO/WHO is committed to promoting greater attention to health, by mobilizing political will at the national level so as to introduce more equitable health delivery that is more in tune with the country's needs.

High rates of maternal mortality are obliging Guatemala to take urgent steps to protect motherhood.

Low health coverage

Inequity can also be seen in the low coverage of education and health services, resulting in high levels of malnutrition, disease and illiteracy, high rates of school drop-out, and limited access to credit and modern technology, all of which are obvious barriers to local self-management and prevent sustainable development.

Poverty and the centralization of government power that excludes communities from policy decisions

and local economic planning have created social tensions and armed conflict for more than 30 years, thereby frustrating the efforts of many Guatemalans who wish to live and work in peace. Fortunately, a wide political process supporting decentralization is in progress, and an agreement on peace talks between the government and the parties involved in the conflict may soon bring definitive peace. All parties recognize that it is only by getting to the roots of inequity that conditions for sustained peace and social reconciliation will truly be established.

Health is fully recognized as a factor for cooperation which can help to overcome ideological differences, build peace and give a stimulus to development. It is in this context that PAHO/WHO is committed to promoting greater attention to health, by mobilizing political will at the national level so as to strengthen the sector. Action has been taken at various levels in the system to introduce more equitable health delivery that is more in tune with the country's needs.

In line with the country's decision to develop priority regions, PAHO/WHO has begun to decentralize technical cooperation by establishing suboffices in those regions, stimulating multisectoral action based on primary health care and organizing local health systems within broader projects of social and economic development. This approach to technical cooperation, by encouraging local skills, has enabled the authorities to tackle the health problems of the marginalized populations more comprehensively.

Interagency cooperation

This form of technical cooperation has helped to bring about close interagency coordination backed by UNDP, UNICEF and FAO, as well as cooperation with bilateral aid agencies such as USAID, SIDA, NORAD, DANIDA, FINIDA and others. A number of nongovernmental organizations active at the local level have also joined in this process. The initiative has benefited from the technical and financial support of intensified cooperation by WHO.

The indigenous population has special need to be protected from the declining standards of living

Special mention must be made of the PRODERE project carried out in the municipalities of Ixil and Ixcan, in the Department of Quiché, in conjunction with various United Nations agencies, including PAHO/WHO, and with financial support from the Italian government. The project has initiated integrated development activities aimed at restructuring the social fabric among displaced populations, returnees and refugees from the armed conflict, especially in the fields of education, agriculture, employment, human rights and health.

PAHO/WHO has supported initiatives to strengthen local activity in a number of priority areas, including:

- promoting the health component as an integral part of human development, in particular in those areas, such as Huehuetenango and Quiché, where the government, in conjunction with the UN and other agencies, is promoting poverty alleviation projects;
- training health services managers through a postgraduate course in health management;
- strengthening skills in local administration among intersectoral leaders such as governors, members of development councils, mayors and so on;
- encouraging the establishment and decentralized functioning of technical schools to train human resources for health;
- training departmental epidemiologists and incorporating epidemiological and information systems as instruments for decision-making at the local level.

PAHO/WHO acts in close coordination with the authorities of the Ministry of Health and Social Welfare, to which it offers support in policy formulation. It helps to promote intra- and intersectoral work during the current process of economic readjustment, and to devise projects in local health care that have the full backing of the central programmes. ■

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Better management for better health

Maria C. Ribeiro

WHO, the government and villagers themselves are collaborating to bring about health for all

A programme in Guinea-Bissau to strengthen health management at regional level, thereby reducing the gulf between policies and realities, is reaping the dividends of better team work, more effective use of existing resources and improved service outputs, especially in vaccination coverage.

The small West African country of Guinea-Bissau has around one million inhabitants who are counted among the poorest in the world. In 1991 it was estimated that their annual per capita income was only US$ 191. Mortality and sickness rates are particularly high, and only two-thirds of the population are believed to have access to the most elementary of health care services.

A study of the way the health services function, which was carried out in three regions with technical support from WHO and financial aid from UNICEF, showed major operational problems that prevented effective implementation of primary health care. Those responsible for health care at the regional level were functioning without success, and routine issues became problems and were dealt with under "crisis management".

The regional Health Directors are mostly young doctors, with no training in management and no experience apart from clinical practice at the central hospital. The Ministry of Health has therefore recognized the need for a strategy that would prepare regional health management staff to function effectively within the health system.

Consequently, a Programme for Strengthening Health Management was designed, based on initiatives developed in Ghana and the Lao People's Democratic Republic, in order to *improve primary health care implementation*. The primary object was to improve the competence and performance of those responsible for regional health services, on the assumption that increased competence will improve managerial performance and lead to better service delivery, thereby improving the health status of the people in Guinea-Bissau.

The strategy of this programme requires that teams analyse day-to-day problems, plan how to tackle them using the available resources, and critically review the results. By working in a structured manner with the support of trained facilitators, they will progressively gain confidence in their role as managers. The programme for strengthening health management is not a formal training programme, relying on theoretical skills; rather, it encourages teams to put plans of action into practice, particularly in the field. Health management teams pass through three modules, each with its workshop and a period for implementing the plans developed at the workshop. The overall duration of the three workshops and periods of implementation is about sixteen months.

Evaluating progress

The programme, which started with WHO support in September 1990, at present covers eight of the ten regions; however only four – Bafatá, Biombo, Cacheu (including São Domingos), and Oio – have completed it. Although it is difficult to assess the outcome of management development in terms of improved health status, it is already clear that the staff's management skills and performance, particularly their methods of work and communication, have improved.

This programme has led to the *creation of new management structures*, and the regional health management teams are now *better*

Women provided with better access to health services have more chance of enjoying safe motherhood

adapted to the strategies of primary health care. **Active participation of all team members is an essential ingredient of this management development process, creating a new sense of responsibility and accountability within the group. Due to their strong motivation, the teams meet regularly, and have realized that despite their scarce resources, progress is visible with concrete results. With increased self-confidence and motivation and through sharing of responsibilities, they have become multipurpose workers and most teams carry out joint activities. This particularly applies to the supervision and reorientation of health workers in the basic health units.**

The programme has achieved other tangible results: vital systems to support primary health care implementation have been developed and become operational, especially in the field of continued training of health workers. Health centres are now regularly supervised; drugs are supplied and distributed, on demand, to the periphery; information, required for management, is routinely collected and analysed; existing resources are more rationally used; means of transport are shared by team members in accord with jointly defined priorities; collaboration with bilateral and nongovernmental organizations is more effective; and serious consideration is given to priority needs for external aid allocation.

Improvements are also seen in the way technical programmes are operated. The only nationwide figures, existing since 1989, apply to immunization coverage. The regions that were selected to benefit from this programme had, on average, much lower coverage than other regions. From 1989 to 1992, the increase in immunization coverage was much higher in the regions covered by the programme than in the others; they also attained a better overall coverage, especially for BCG vaccination and for DPT3 (diphtheria, pertussis and tetanus vaccine). It seems that the programme has, together with other factors, contributed to this success.

It is also worth noting that regions have started to collaborate, particularly in the area of support to health centres and continuous training. Lessons learned from health systems development at regional level are regularly shared with decision-makers at central level. As a result the national health policy is being reviewed, based on regional experiences in reorganizing their health systems.

Successes, already achieved by the programme in Guinea Bissau, are due to several reasons. Firstly, *the context*: there is political will to decentralize the health system and strengthen the regional level. Secondly, *the strategy*: it is coherent and based on such important principles as team work, ownership, adaptation to prevailing conditions, repetition, progressive apprenticeship, and support between workshops. Finally, *the management of the programme*: the Ministry of Health has set up a national network of "facilitators", responsible for planning and implementing this programme, in its entirety, throughout the country. Technical, logistical and financial support, amounting to US$ 18 000 per region, has been offered to this network by the World Health Organization. ■

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Offsetting the impact of currency devaluation in Africa

The 50% devaluation of the CFA franc on 12 January 1994 came as a great shock to the African countries concerned – French-speaking nations of the Communauté financière africaine (Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Gabon, Mali, Niger, Senegal and Tongo). The consequences go far beyond simple financial adjustments in the short term. Countries of the franc zone and their development partners have put and will put in place specific measures aimed at protecting the populations, particularly the most vulnerable groups, in such fields as education and health.

Some short-term effects can already be seen, but there must also be concern about the long-term consequences in all sectors of society. Devaluation could bring about catastrophic changes for certain social groups, but it may also turn out to be a blessing if it becomes an opportunity for reorganizing sectoral activities in a way that can prove beneficial for everybody.

The consequences of this devaluation and lessons that can be drawn from it will be examined in Geneva on 21-24 February 1995 at a conference organized by WHO – in collaboration with UNESCO – on "The impact of the CFA franc devaluation on the social sectors. One year after: a balance sheet for action."

This meeting will bring together senior officials of the Ministries of Health, Education and Planning from the 14 countries of the franc zone, as well as technical experts from the international organizations and from the countries that are partners in development.

Two faces of poverty

Oswaldo Lazo

Inequality and injustice lie at the root of poverty in Peru. Yet ancestral principles of survival based on solidarity and reciprocity that were the basis of the social structure in the pre-Hispanic world have ensured that thousands of mothers' clubs, educational groups and other associations are now working to improve health, sanitation and water supplies.

Peru is a poor country, and getting poorer day by day. For years its people have lived in a kind of illusion born of the well-known saying that Peru is like a beggar sitting on a golden bench – a reference to the country's great variety of natural resources and its diverse ecology and climate.

The geographical diversity of the terrain is matched by ethnic differences, making for a country in which many different cultures coexist, different languages are spoken and the population forms several different nations that are not yet fully integrated, so that it can be said that Peru is a nation in the process of formation. Inequality and injustice lie at the root of the poverty of the Peruvians, which prevents the full unfolding of the country's potential for human development.

The deep global crisis that began in the mid-1970s led to tremendous hyperinflation, high unemployment and a huge contraction in government social spending. These evils were accompanied by an upsurge in organized political violence, in which an estimated 20 000 people died.

In Peru, 60% of the population live below the poverty line.

Still greater hardship

On this critical background, a set of extremely harsh measures of economic adjustment were applied at the beginning of this decade, and various studies have shown that they have substantially increased the numbers of people living in poverty, as they have not been accompanied by actions to offset their adverse effects on the living standards of the poor. Today we are facing a phenomenon of massive poverty affecting 60% of the population. The extremely poor account for 22% and are mostly found in the rural areas of the Andes mountains, beyond the reach of even the most basic social services.

The infant mortality rate of 55 per 1000 live births is one of the highest in Latin America, while the rate in the rural Andean areas is as high as 91 per 1000. There has been a decline in coverage by basic sanitation services; whereas at the end of 1960 it was estimated that 60% of the urban population had a piped water supply, by the end of 1990 only 42% had this service and in the rural areas only 36% had access to a household water supply source or connection.

Lack of access to health care and the inability of such services as existed to provide prompt and adequate care were brought sharply to light with the outbreak of the cholera epidemic at the end of January 1991, for it is well known that cholera is a disease of poverty directly related to sanitary conditions and the level of people's awareness of hygiene. The epidemic produced 390 000 cases in the first year, with 4000 deaths, in spite of the fact that a whole set of emergency measures, including the monitoring of food and water and the early detection and treatment of cases, were introduced by

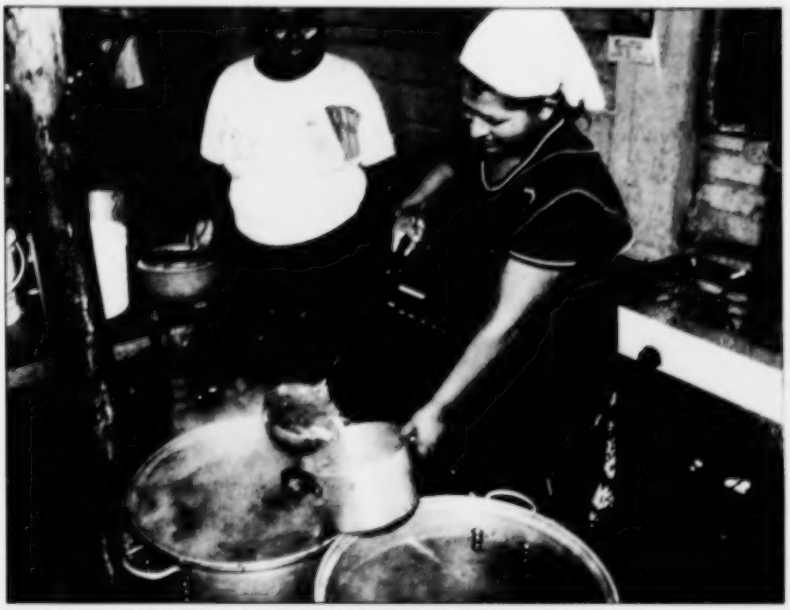
Tap-water in the home is an undreamed-of luxury for millions;

the Ministry of Health and widely accepted by the public.

Despair and hope

Poverty in Peru has two faces. The first is synonymous with deprivation and marginality, which could simply inspire despair, and as such is an evil that must be overcome if the country is to go forward on the path to development. But the poor also constitute a reservoir of human potential – the second face – whose energies can be mobilized to give impetus to processes aimed at improving living conditions. Important organizations have arisen, especially women's movements in defence of life and health which combine their everyday household preoccupations with collective concern about the needs of the neighbourhood or the community. It has been mainly the organized women among the poor who have joined their voices in legitimate protest at past neglect and have come up with concrete proposals and continuing activities for the health and feeding of their children and their families.

The poor from the Andean regions lean on ancestral principles of survival, based on the solidarity and reciprocity that were the basis of the social structure in the pre-Hispanic world. These principles continue to sustain their activities today and have led them to form a variety of organizations that give substance to the social fabric in Peru. In the city of Lima alone, there are today 8000 milk distribution committees, bringing together mothers from the poor sectors of the community to prepare and distribute nearly one million rations of milk every day to children, pregnant women and nursing mothers. In Peru as a whole some 900 000 lunches and 230 000 other meals are subsidized or distributed free of charge.



Preparing meals for collective distribution.

Mothers' clubs, people's educational organizations, crèches and other associations now work for the health of their children, ensuring the community monitoring of children's growth and development; carrying out programmes of food supplementation for children with or at risk of malnutrition; acting quickly to give oral rehydration in cases of cholera and other diarrhoeal diseases; promoting health education and environmental hygiene in their communities; and taking part in campaigns to collect garbage, install latrines, chlorinate the water, and maintain and clean the water reservoirs.

These are just some of the many health activities in which the women are involved, with support from nongovernmental organizations and other national and foreign charitable institutions. In daily practice they are now fully recognized by society and the government, and the formal health services are coordinating their activities with them. It is largely these women, during the cholera epidemic, who were the first to take to the streets in their communities and organize educational marches that made people quickly realize the seriousness of the problem. They were also the first to give prompt oral rehydration treatment, thus preventing deaths and also saving the health centres and hospitals from being overwhelmed; ultimately only 37% of cases were hospitalized. It is thanks to these women and to the health service workers that Peru had a case fatality rate of 0.69% for cholera, the lowest in the world.

These leaders of the social organizations that have emerged from the struggle for survival deserve to be recognized, for they have gained experience and become effective and efficient. Ways should be sought to enable them to participate in the running of health services as legitimate representatives of the people; they have a role to play in sustaining the democratization of Peruvian society and its development in peace and justice. ■

e wait for the water-truck is an everyday fact of life.

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Care for the urban poor

Amitabh Kundu

Routine visit to a big-city clinic.

A considerable section among India's urban poor cannot afford any medical facility. This makes a very convincing case for strengthening the public medical system and providing affordable health care to all sections of the population.

The health care system in India is organized through a network of institutions belonging to both the public and private sectors. Constitutionally, the provision of medical facilities is the responsibility of the state governments and union territory administrations, but the central government shares a part of this responsibility by providing the facilities for its own employees, as well as running certain specialized services and enforcing medical standards. Some local governments (in cities and towns) also supplement the facilities by running hospitals, dispensaries and so on. The share of the government and semi-government agencies in all cases of hospitalization in urban areas works out at about 60%, while the share in outpatient treatments is less than 30%. The medical facilities managed by charitable trusts, other non-profit organizations, companies and private practitioners account for the remaining cases.

In view of the poor health conditions and inadequacy of curative services in the country, the central and state governments have been intervening with special programmes for eradicating the common diseases and removing nutritional deficiencies. These include programmes for eradicating kala-azar, Japanese encephalitis, leprosy, and guinea-worm disease, and those for controlling blindness, tuberculosis, goitre, cancer, diarrhoeal diseases, diabetes, malaria, AIDS and so forth. Through the Child Survival and Safe Motherhood programme, under the Ministry of Health and Family Welfare, an attempt is being made to immunize vulnerable children and mothers against certain communicable diseases and improve maternal and child health.

All these programmes and schemes have undoubtedly made an impact on the overall death rates, infant mortality rates and health standards of different sections of the country's urban population, particularly those of the poor.

For the very poor in Delhi, health facilities are generally free of cost.

Privileged health care

An analysis of the organizational structure of the medical facilities within the public sector, their pricing, and the pattern of delivery makes it clear that – unlike in housing, water supply and sanitation – there is no explicit bias in favour of the poor. On the contrary, a large section of the organized workforce in the country (which constitutes less than 20% of the total workforce), both within and outside the government, enjoys the privilege of having a separate and distinctly better health care system. Under a contributory scheme, known as the Central Government Health Scheme, separate medical facilities are provided to most of the central government employees, who are concentrated in the cities. Some of the Ministries, departments and large public and private sector undertakings have their own network of hospitals and dispensaries. Employees of the defence services and railways, for example, have their own facilities to take care of all their medical problems. A mechanism for referral and reimbursing medical

expenses exists, enabling employees and their family members to have access to specialists and clinical services of a higher order, often outside the government system. The type of accommodation and associated facilities in case of hospitalization depends on the income level – the entitlements being much better for individuals belonging to higher salary groups.

The urban poor, mostly engaged in informal activities, depend almost entirely on state government facilities and – in their absence – on private medical services. Excluded from the special systems that cater for the organized sector workers, they do not get preferential treatment in the general hospitals. The latter are mostly very crowded and provide only elementary facilities, often of a low quality. Only a small fraction among the poor are able to use the referral mechanism to gain access to services of a higher order. This can be attributed to their low level of literacy, lack of awareness or connections and inability to afford to lose wages by taking time off work.

Free treatment but...

The basic medical facilities available to the poor through health centres and dispensaries at the grass-roots level are generally free of cost. Those declaring their income above a certain level are, of course, required to make small payments. But the general health care system is in practice extremely generous in extending the free facilities to almost all sections of the population.

Pricing of the services has not been envisaged as a strategy either for recovering a substantial proportion of the cost or for restricting their use by those who can afford more expensive facilities in the private sector. However, the poor are placed at a considerable disadvantage due to their socioeconomic characteristics. Illiteracy is the single most significant factor explaining their lack of access to medical services. In addition, the distance from the hospitals reduces the accessibility of the poor much more than that of the rich, in an urban setting.

A recent study by the author using data from a national sample made in the 1980s (*In the name of the urban poor*, Sage Publications 1993) reveals that the poor have a larger share in the lower-order medical facilities provided in the public sector. This is due to the wide dispersal of basic health care services through a network of institutions. The poor, however, claim only a small share in the clinical tests and other specialized services that are provided at a price. The heavily subsidized higher-order public services, such as biochemical tests, blood and urine culture, ultrasound, ECG, etc are cornered by the middle- and high-income people.

The public medical system does exhibit a sensitivity in favour of the poor. The bottom 37% of the urban population claim over 46% of the treatments in the public hospitals and dispensaries. In the private sector, the pattern is just the opposite. However, about 48% of the urban poor go to private doctors and another 12% to private hospitals for outpatient treatment in an emergency and when the public facilities are unsatisfactory. It is unfortunate that most of the hospitals managed by missionaries and philanthropic organizations function just like private nursing homes, earning enormous profits.

The fact is that a considerable section among the poor cannot afford any medical facility. A large majority of them report lack of finance as the primary reason for not getting their ailments treated. All this makes a very convincing case for strengthening the public medical system and for providing health care facilities at affordable rates to all sections of the population. ■

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Health insurance in Viet Nam

Bui Duc Khanh

The notion of health insurance is just scratching the surface so far in Viet Nam, reaching only 5–8% of the population. Many years of having a subsidized health system have led to a form of habitual complacency. The well-to-do are quite ready to pay for care if they fall sick and are not interested in health insurance, which the poor feel they cannot afford. But the hope is that the insurance scheme will eventually ensure greater access to care, and better quality of care, for all patients.

Viet Nam underwent more than 30 years of terribly destructive warfare followed by many years of an international trade embargo. It is also regularly battered by natural calamities. Most of its people – 85% – are engaged in agriculture; by nature they are dogged and industrious, but most of them have hard lives, beset by poverty and disease.

In the past, thanks to the state subsidy system, they could expect examination and treatment free of charge at health facilities if they fell ill. But today the national health budget is barely enough for the delivery of health services, and can only respond to about half of the minimum health demands. There are

Viet Nam's insurance scheme will eventually ensure better access to health care for all its people.

increasing shortages of such items as medical equipment, chemicals, drugs and X-ray films. Since 1989, in an effort to overcome the erosion of the social services, the State has allowed health facilities to collect a portion of the hospital fees. The very poor still receive free treatment, but what is collected from patients who are able to pay represents only a minor proportion of what is spent on them. Throughout the entire health service, hospital fees amount to 8–10% of the total expenditure on hospitals. Still, despite this relatively modest share of charges in total expenditure, many people are worried that if they fall seriously ill, they may have to borrow money in order to pay the hospital charges.

In 1993, the Health Ministry passed a decree obliging all civil servants and wage-earners – some 10% of the total population – to contribute 3% of their income to health insurance: 2% paid by the employer in the public or private sector, and 1% paid by themselves. One year after the scheme went into action, less than half of those concerned have actually joined the scheme; still uninsured are some employees of private companies and some self-employed persons.

Of the people not belonging to the compulsory scheme, the great majority are peasant farmers or small traders. The poor and very poor constitute between 15% and 20% of the population; they know that if they make enough money they can join the health insurance scheme and their anxieties will be eased, but they tend to accept their fate with resignation.

Pilot scheme

Some time ago, the Vietnamese Health Ministry introduced a pilot health insurance scheme in the region of Haiphong which, besides

A helping hand to cross the flooded street. Natural catastrophes regularly pose special problems for the health personnel.

A calendar helps to promote the messages of good health for all the family.

Breastfeeding for a new-born baby in the "rooming in" ward of a provincial health centre.

being a major port city, includes rural districts. Thanks to the enthusiasm of the Haiphong people's committee and of those who actually run the scheme, membership increased rapidly in some districts from 5% to 25% of the residents. With the help of WHO consultants, the scheme is being extended as a policy-oriented research project to other districts, each with a population of nearly a quarter of a million. About 10% of households have a relatively high standard of living, well over half a medium standard, and 20% a low standard.

In a matter of months after the pilot scheme was introduced, all the localities concerned have demonstrated initiative and ingenuity. Its leaders include not only administrators, members of workers' and peasants' unions, youth organizations and women's groups, but also schoolteachers who have been encouraging the children to tell their parents about the health insurance scheme, and priests. Women and the elderly constitute two groups who need little persuasion to invest in the scheme, once they realize that it will relieve them of the worry of facing unexpected expenditure on medical or hospital care. Health insurance cards are being offered to parents and grandparents as birthday or anniversary cards, and can even be paid for with rice or other farm products.

So far, the notion of health insurance is just scratching the surface, reaching only 5–8% of the population. Many years of having a subsidized health system have led to a form of habitual complacency. The well-to-do are quite ready to pay for care if they fall sick and are not interested in health insurance, which the poor feel they cannot afford.

The research team hopes that, with the backing of the Health Ministry, the authorities at different levels and WHO, the initial experiments in Haiphong and elsewhere can be built upon. The experiences of such countries as France, Germany and Sweden as well as those of neighbouring countries like Thailand are also being studied, and the hope is that Viet Nam's health insurance scheme will eventually ensure greater access to care, and better quality of care, for all patients. In particular, the poor will at last have a solid basis for meeting their health needs and will be able to take pride in the fact that they are taking care of their own health. ■

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Global commitment needed

Before national authorities worry about the cost of tackling the manifold problems that will beset us in the next century, they might well consider what would be the cost of not tackling them. Failing to deal adequately with rapid population rise, unchecked migration, poverty, inequity in health, insanitary conditions and unhealthy lifestyles amounts to a recipe for disaster. The consequences must inevitably include social disruption, greater political and religious extremism and a tendency for local tensions to escalate into national and international conflicts.

Therefore, administrations need to consider the high political cost of inaction. Heads of state and of government must act as catalysts for a global commitment to action to improve the quality of life of people everywhere. The very stability of those heads of state and of government may depend on this!

The sorry history of the present century offers sufficient proof that social tensions do not stay within national borders. They travel, transforming themselves into such issues as migration, drug abuse, diseases, poverty and terrorism – in short, issues that do not lend themselves to narrow national solutions but must be resolved at the international level. Today, and tomorrow, we need to assess whether present development models and current international cooperation are truly responsive to the needs of sustainable human development and whether they contribute to lowering tensions and improving human well-being in our global village.

Based on a text by Ambassador Juan Somavia, Chairman of the Preparatory Committee of the World Summit for Social Development. Contributed by Dr Habiba Wassef, Division of Interagency Affairs, World Health Organization, 1211 Geneva 27, Switzerland.

Bad housing = bad health

Cathy McCormack

What has a Glasgow housing scheme in common with a poor barrio in Nicaragua? The writer learnt that, in both, it is not enough to have a health care system that treats the symptoms. It has to tackle the root cause of the problem.

Greater Easterhouse is Glasgow's largest public postwar peripheral housing scheme. Originally created to accommodate the massive slum clearance of the inner city in order to address Glasgow's appalling health record, this new housing estate was – according to the government – needed to bring "good health" to the people in Scotland. Instead it became a most unhealthy area, with its flats infested with mould because of the damp conditions. Recording the highest levels of multiple deprivation of any other city in the UK, Glasgow's housing estates are part of the Fourth World (i.e., pockets of abject poverty in affluent countries).

Like the oppressed people in the working-class communities throughout Britain, the people in my community suffer the same pain and the same negative imagery as our counterparts in the Third World. My own nightmare began after the birth of my children. My only thought for their future was for them to be happy and healthy. All my children were over 8 pounds (about 4 kg) in weight and bouncing with health. But once I brought them home to our flat, they soon lost their bounce and the doctor became a regular visitor. Although I had always lived in a freezing cold, damp house and spent a lot of my childhood in hospital, in my ignorance I had never made the connec-

When upgrading of this building came to a halt, the tenants had to cope with cold draughts and the risk of burglary.

Families drew up a petition in a communal effort to obtain better housing conditions.

tion between our living conditions, ill health, and the social and environmental climate.

In order to take back control over my children's lives, I joined the citywide anti-dampness campaign. Easthall Residents' Association (ERA) has been in existence for 20 years and has been involved in numerous issues affecting the community. At their Annual General Meeting, angry tenants set up a "dampness task force" to challenge the Glasgow District Council which was responsible as our landlord for keeping our flats in good repair. But the Council kept blaming the tenants' "lifestyle" for the dampness, and spent unknown amounts of money treating the symptoms by using chemical washes to try to kill the fungus.

The Dampness Group realized that their first task was to get evidence to prove their commonsense approach. Our research showed that an estimated quarter of a million people in Glasgow (84 000 homes) and a very conservative estimate of 10 million people nationwide, shared our struggle against damp housing. We estimated that families in Easthall were paying £1 million (about US$ 1.56 million) between them each year heating the sky above Glasgow, because the heat went straight out of their windows and walls. None of the houses had central heating.

Presented with all this evidence, Glasgow District Council finally admitted that there was a housing problem but had no money to put things right. When it was revealed that Glasgow had an appalling health record and had one of the highest premature death rates in Western Europe and was nominated heart disease capital of the world, it came as no surprise to us. What did surprise us was that the blame was put on our diet of greasy fried fish suppers and general lifestyle.

The authorities launched their "let's all go out jogging, stop smoking and eat brown bread" health promotion campaigns. These people had not a clue about our reality; it was not keep-fit exercises that we needed but homes that were "fit" to live in.

"Housing makes you Sick"

The turning point in our campaign came in 1987 when the ERA and our allies worked together on two unique initiatives – the Heatfest Housing Project and "Housing makes you Sick" – the largest fully independent survey into housing and health ever carried out in Britain. We were determined to get public health on the political agenda and to dispel the myth that smoking, diet and lack of exercise were solely responsible for Glasgow's heart disease record. Together with the Scottish Solar Energy Group, we organized a three-day ideas competition in Easthall in January 1987 called "Heatfest". The event attracted people from all over the UK, including architects, quantity surveyors, engineers and energy conservationists.

Together we spent many painstaking months refining the best features from all the entries into one package, and then applied to the Commission of European Communities Energy Directorate for 30% of the funding to put our estimated £1.3 million (US$ 2 million), Easthall Passive Solar Energy Demonstration Project into practice. Glasgow District Council supported Heatfest, but declared that there were no resources to implement any radical outcome.

In December 1989, the European Commission said that our application

had been successful, and we were the first tenants' group to be awarded £400 000 (US$ 625 000) provided we secured moral and financial support from our landlord – Glasgow District Council. Just before our deadline was reached, the Council granted all the remaining funds.

The flats in Easthall were super-insulated, central heating was installed and glassed-in extensions provided desperately needed clothes-drying space. Solar panels on the roof heat the stairwell and pre-heat the cold water in the tanks which are situated in the lofts. The verandas were glazed in, giving extra insulation and functioning as a reservoir of heated air to ventilate the bedrooms.

Fruit instead of mould

The project was completed in 1992. Already the tenants here have seen their fuel bills reduced to about £7 ($11) per week for whole-house heating and they can now grow fruit instead of mould and other varieties of fungus! The benefits extend still further, as the tenants can afford a decent diet and the landlord will save on maintenance repairs and on condensation claims. The tenants are happier and healthier. One teenage tenant, who was a chronic asthmatic and attended hospital three times a week, has never needed hospital treatment for her asthma since moving back into her Heatfest home.

Thanks in part to our housing survey, Glasgow District Council are now committed to spending 60% of their housing budget trying to eradicate dampness, fuel poverty and the associated health problems. So our project has demonstrated that, when people at the grassroots really get listened to, the benefits go far beyond our own social and economic environment.

In July last year, I was sponsored by a number of organizations to go on a Health Study Tour of Nicaragua to witness at first hand their popular, positive health initiatives. It was the most inspiring experience of my life to go to the other side of the world and hear people talking the same language. The grassroots movement (*Movimiento communal*) sees participation by the people as essential to the health of that community.

Although I don't speak Spanish, the pain of poverty has its own language. I laughed when Alfonso, a community leader from one of the *barrios*, described how his community is regarded as the lowest of the low and the people are often referred to as "the underclass". I told him that I came from a poor *barrio* in Britain and that we were no longer referred to as people either.

We hugged each other before leaving, unashamed to embrace the common spirit of humanity. I hope, by sharing the struggle and vision of the people in both "worlds", that more people will be inspired to "blow the trumpet" which will one day sound the tune for the march of humanity towards progress. ■

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The new underclass and re-emerging diseases

Diane Seligsohn

The resurgence in infectious diseases observed during the 1990s appears to be linked to the growing poverty and deprivation of a new underclass in many European and North American cities.

The discovery of antibiotics in the post-Second World War period, coupled with the development of reliable vaccines, was heralded by the international medical community as the beginning of an end to infectious diseases. While it would take longer in the developing world, those fortunate enough to live in the industrialized countries could expect eradication of many of these afflictions in their own lifetimes.

Yet a number of these diseases not only persist but are actually on the rise in Europe and/or the United States. In France alone, infectious, parasitic and respiratory diseases caused more than 24 000 deaths in 1990, twice the number recorded in 1980. Mortality due to pneumonia, for example, tripled in one decade.

The emergence of AIDS is obviously an important contributing factor, but it does not suffice to explain the return of older killers. Their resurgence points to a basic fallacy in the optimistic predictions made several decades ago: they failed to take into account the dramatic influence that changing living conditions can have on health. In fact, the incidence of many infectious diseases began to regress in the Western world at the beginning of this century, well before the advent of effective prevention and treatment.

A new underclass

Epidemiologists agree that this was probably due to reduced overcrowding and improved nutrition, social conditions, sanitation and health care. Likewise, the resurgence in infectious diseases observed during the 1990s appears to be linked to the growing poverty and deprivation of a new underclass in many European and North American cities.

In New York the inequalities between rich and poor are most striking. Over half of the people who have tuberculosis are blacks. The risk of catching the disease is 35 times greater in Harlem than in the city's smart neighbourhoods. Statistics show that the risk of contracting tuberculosis for a New York child aged under 15 increased by 300% between 1987 and 1991. While the prevalence of the AIDS-causing human immunodeficiency virus (HIV) is an important factor in this rise, experts believe that poverty and social deprivation play a part.

Of course, wealthier citizens may live and travel in overcrowded conditions and run exactly the same risks of contracting the disease in the presence of infectious persons. But poor people often have limited access to health care services, are less likely to be able to afford the tuberculosis drugs they need and will continue to

infect others in their community. Better-off communities have easier access to the almost 100% effective combination of drugs and can generally be cured.

The return of tuberculosis in Western countries is due to a complex set of causes that can all be aggravated by poverty: the deterioration of health care services in many industrialized countries, increasing mass migration, and the HIV epidemic. Among individuals who carry the tuberculosis bacilli, those with immune systems compromised by HIV are 30 times more likely to develop tuberculosis than an HIV-negative person.

Unbalanced diet

Just how does poverty influence the incidence of infectious diseases? One of the simplest answers is that it tends to go hand in hand with malnutrition, either because there is not enough to eat or because the diet, often high in sugar and fat, is unbalanced. Malnutrition, in turn, diminishes the body's resistance to infections. A vicious cycle is created, where infection predisposes to loss of appetite, weight loss and, ultimately, malnutrition.

Today's urban poor, like their 19th century counterparts, often live in small, overcrowded apartments, where hygiene is lacking. Such promiscuity favours the propagation of infectious diseases, especially those that are spread through the air in respiratory droplets. This is the case not only for tuberculosis but also for leprosy, which today is on the way to being eliminated, thanks to multidrug therapy (MDT). But far from belonging exclusively to the developing world, leprosy still exists in the poorest countries of Europe, including Greece, Italy, Portugal, Romania, Spain, Turkey and some regions of the former Soviet Union.

The wave of diphtheria affecting Russia and Ukraine is another example. Transmitted through the air or water, the disease can be largely prevented by vaccines and booster shots. When the diphtheria epidemic broke out last year, immunity in adults was decreasing and many children were not vaccinated because immunization programmes had been neglected. The situation was further aggravated by large migrations of people from the war-torn areas. In fact, transport workers – in close contact with large numbers of people at railway stations and airports – are at great risk of contracting the disease. Alcoholics are another high-risk group because of their lower resistance and their lifestyle.

Civil wars create conditions that favour the outbreak of infectious disease. People deprived of food have weakened immune systems and they may be obliged to drink contaminated water; the lack of garbage collection attracts disease-carrying vermin. Such conditions have been responsible for epidemics of hepatitis as well as diphtheria in the Bosnian capital, Sarajevo.

Inadequate social security

Many infectious diseases affect people of all socioeconomic brackets. But there is a higher incidence and higher severity among the poor, either for lack of treatment or as a result of premature

Hungry and homeless in the Paris underground. Being deprived of food weakens the body's resistance to disease.

interruption in the treatment. This is particularly the case where social benefits are inadequate or non-existent.

Although the current American administration is committed to tackling this problem, at present 15% of the US public have no medical insurance. In France, reputed for its generous social security system, a research study published last year showed that more than one person in five (21.7%) felt obliged to go without some form of basic health care, including medical consultations and X-rays, for lack of money. Unqualified workers (27.9%) were twice as likely as top executives (15.3%) to restrict their use of health services, and 32.8% of the unemployed went without care for financial reasons.

In some European countries, the purchase of certain medications and vaccines (hepatitis A, for example) is not reimbursed at all, even when people are eligible for benefits. In theory, several countries provide free care for the needy, but this does not always work in practice. In France, the waiting period between a request for medical assistance and its being granted can be as long as six months. Persons who may be uneducated or illiterate simply cannot wade through the bureaucratic maze of paperwork that is often a necessary preliminary to treatment.

Many poor children never receive the vaccinations that could protect them from falling prey to infectious diseases. In France, an upsurge in whooping cough has been attributed to the non-vaccination of babies. According to a recent report by the Carnegie Foundation in New York, 60% of American two-year-olds still had not been immunized against the most common childhood diseases. This is one explanation for the recent increase in measles cases in the United States.

The homeless are at particular risk of catching infectious diseases, especially in certain public places where they congregate (the underground, bus and railway stations). Concentrating their energy on basic survival, they no longer look after their health. When rounded up by the police, the sick are sent to hospital which, ironically, is not always the best solution, since hospital-related infections may worsen their condition.

The current situation places a heavier burden on public health systems for preventing, screening and treating infectious diseases, but they are ill equipped to meet the challenge and many are becoming impoverished themselves. This is particularly the case in the countries of the former Soviet Union, where health budgets have been slashed. Although care is still free, the vaccines and drugs necessary for fighting infection are often lacking.

But whether in Eastern or Western Europe or in North America, the problem is also one of commitment. Responding to the belief that infectious diseases could be vanquished by drugs alone, health officials and scientists turned their attention elsewhere and focused their efforts and funds on such modern ills as heart disease and cancer. In view of the limited resources, it is surely time again to reconsider priorities. ■

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Isolation may lead to squalor

Letizia Toscani & Dominique Ulkü

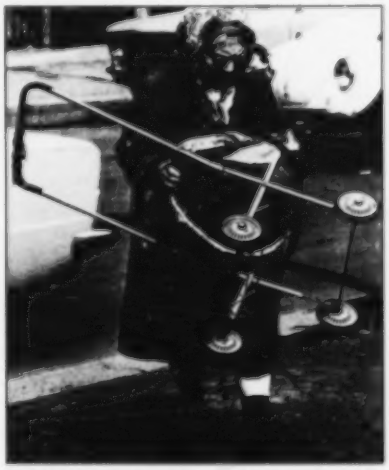
Most of Geneva's citizens live comfortably and enjoy a wide range of social services. But for all that, unhealthy conditions have not disappeared; they just have a different face – that of old age and solitude, that of exclusion. Medicine describes the victims' problem as the Diogenes syndrome, named after the philosopher who rejected all social conventions and lived in a barrel.

Lonely in a crowd. City life can be particularly harsh for people who don't conform to the norm.

The city of Geneva and its adjoining canton, lying at the extreme south-western tip of Switzerland, enjoy one of the highest standards of living in the world. Yet there is another side to this gleaming coin: the unhealthy conditions into which certain people drift because they are deprived of satisfactory social relationships.

The Geneva public health services, which now include the Cantonal Physician Service, have been in place for centuries to deal with problems of unsanitary conditions. In the past these were generally the consequence of poverty and its everyday companions – ignorance, unemployment, alcoholism. The public health doctors of the time had the damp slums pulled down since they were thought to encourage tuberculosis, they banned people from raising rabbits in the stairwells, and they fined all those who – having no access to sanitation – emptied their chamberpots into the street.

Today the large majority of Geneva's citizens live comfortably and sometimes in luxury, while the wide range of social services available to them has dispelled the misery of the past. But for all that, unhealthy conditions have not disappeared. They just have a different face – that of old age and solitude, that of exclusion.



For many people, old age is synonymous with solitude and exclusion.

The case of Mr C

The neighbours sign a petition complaining about the smell that for several months has emanated from the apartment of Mr C, a tenant for 30 years.

As Mr C has no telephone, we write to him proposing a meeting and we show up on the date suggested. He does not appear and our letter is still lying in his letterbox. But thanks to the description given by a neighbour, we manage to identify him in the street, just as he emerges from his favourite cafe. He accepts the beer that we offer him.

Aged 78, small and shy, he tells us about himself. He spent his childhood on a farm in a neighbouring canton. He came to Geneva as a young man to work as an usher in a cinema. His eyes gleam as he recalls the little torchlight with which he guided spectators among the red plush seats, and he draws himself up as if to put on once again his uniform with its gilt buttons. Then one day the cinema was equipped with floor-level lighting and Mr C was dismissed before he reached retirement age. Social security does,

however, assure for him a reasonable material existence.

Without any friends, cut off from his family by distance and years of separation, he tries to recreate the ambiance of his cinema days in the bar at the corner. He always sits in the same place. He drinks four beers throughout the day, to which he adds – and this is all the food he takes – a few biscuits. When the young waitress greets him with a smile, he still has his moments of happiness. With a shy smile, he confesses to us: "She is my girlfriend".

Finally he agrees that we may go home with him. He introduces us to his only real companions: three cats. They are plump and in excellent health, an astonishing contrast with the leanness and poor health of Mr C. The apartment is filthy, both WC and washbowl are blocked up, and the kitchen is piled high with rubbish.

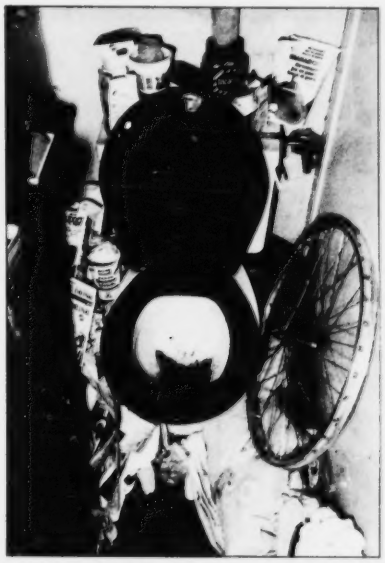
We suggest a stay in hospital to assess the state of his health and we offer help in cleaning up his flat. He refuses... he could not leave his cats and, besides, he wants to manage on his own. Some weeks after our visit, Mr C is found dead in his apartment. The mewing of his cats alerted the neighbours.

Solitude as a way of life

Geneva now has more than a hundred individuals whose stories, although different, have points in common with that of Mr C.

In a society which is so demanding in terms of what is expected of each individual, human relationships are becoming impoverished, and these are people who have not known how or have not been able to establish solid social ties. Through apathy? Because they wanted revenge for injustices which they believe they have suffered? The fact remains that they have been ignored or rejected by other people. Over the years, their solitude has become more and more profound through the loss of people close to them or of cherished objects – a wife or husband, a job, health – and solitude has come to be their only way of life.

In turn, they reject this society which has given them so little, until they neglect the elementary rules of hygiene, keep their shutters closed, no longer check on their letterboxes, leave their bills unpaid and rebuff anyone who comes to help change their style of life. In the lonely chaos of lodgings littered with objects or animals, they seem somehow to find a certain peace.



Social neglect is reflected in neglect of health and hygiene.

Medicine has found a term from Greek mythology to describe their problem: the Diogenes syndrome, named after the philosopher who rejected all social conventions and lived in a barrel. Yet there is no prescription that can cure these people of the failure of their lives. Intervention by the medical and social services can only seek the humble goal of helping these modern-day Diogenes to be tolerated by society, while respecting as far as possible the lifestyle which they have evolved for themselves. ■

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The indifference of society leaves people marginalized, abandoned to self-neglect.

Community action

Love in action

Jitendra Tuli

During this year's World Health Assembly, delegates and other health experts participated in Technical Discussions on the theme of "Community action for health". The story of Omvati, described below, shows how health professionals can train individuals in the community to improve each community's health status.

Omvati's day starts at the crack of dawn, just as it does for most other women in her small village of Jhimerheri, in Haryana, about 130 km from India's capital, New Delhi. After tending to the cattle and taking care of the household chores ("a woman's work never ends", she says with a smile), she prepares the morning meal for her two young sons and husband. She then quickly cleans up her modest front-yard which also serves as a "balwadi" or children's day-care centre.

By 9 a.m. most of the 25 children brought to her creche for care and supplementary nutrition are assembled. Every Saturday afternoon the older children enliven the centre with their excited chatter and their songs, while Omvati's gentle but firm voice tells them how they can stay healthy and help others in their family do the same. Through short plays and songs and demonstrations, the children participate in activities that drive home the message of good health. During these sessions, Omvati's husband, Ram Phal, a farmer, joins in the singsong and helps when he can.

This happy picture, however, is not the way it was even eight short years ago. Then, as Omvati tells you haltingly, her life was not much better than the cattle she tended. Their home was nothing more than a thatched roof propped up with some poles. There was constant bickering at home. She, like the other women in the village, observed strict "purdah" which made contact with outsiders virtually impossible. As she recalls those sad, earlier days when her younger son was only a few months old and the older one was about three, she would hide them, and herself, when she heard that the doctors had come to give them injections. Why? "Because I knew that the children would get fever and, with all the problems I already had, there was no use adding the burden of a sick child. Who would look after them? Who would look after me? How would I ever cope with the work?" The questions tumbled out.

Then, one day, the local teacher came to her husband and told him that the nearby Arpana Hospital was looking for women to be trained as community health workers. "I overheard this and decided that I would approach the hospital. I had only passed my 5th class, but was desperate to do something useful. Of course, there was opposition at home, but I was determined to go ahead and was delighted when I was accepted for training". After three months of intensive training, she started her assignment in her village.

A life transformed

"And my life was truly transformed. Gradually, with experience, I began to take part in various other health activities. See, these are the records I maintain," she says proudly, showing her registers and the forms that she fills in meticulously and gives regularly to the Arpana hospital. Having started out with an allowance of 300 rupees (US$ 10) per month, she now earns 800 rupees per month, which, she says shyly, is more than what most of the menfolk in her

Omvati, who used to hide from health workers, is today an active health crusader in her village.

village earn.

Arpana, which means devotional offering, has not only transformed Omvati's life but the lives of nearly 45 000 inhabitants of the 36 villages which the Arpana Research and Charities Trust has "adopted". In recognition of its outstanding innovative work in health development, the Trust received the Sasakawa Health Prize for 1993 during last year's World Health Assembly in Geneva.

The dedicated volunteers of Arpana see this recognition not as the culmination of their dreams, but as the beginning of a new thrust with the blessings of "Ma" or mother, the divine guiding spirit who has always urged those around her to render true service, through which "you elevate and exalt others, and find the path to happiness".

Today, just over a decade after they ventured into health care in a holistic manner, Arpana's "love in action" programme covers diverse health-related areas focused on eliminating illiteracy, ignorance and malnutrition, and on controlling preventable diseases and reducing economic deprivation. As Omvati recalls, before Arpana came into their lives, the infant and maternal mortality rates in her village were high; these have now improved dramatically. Arpana has a three-tiered health service programme which consists of a 75-bed base hospital, at present being expanded, primary health care units catering to the villages, and mobile units which visit each centre once a month. The hospital serves as a referral base for the rural health care programme and as a training centre for all village-level health workers.

As with the other facilities provided, these are highly subsidized for those who can pay and free for those who cannot. In turn, Arpana raises resources through donations, and through the sale of its handicrafts which provides welcome additional income as well as training opportunities to the rural women. So far, more than 1300 women have been trained and their exquisitely hand-embroidered garments and linen are finding ready markets in the country and abroad. Recently, Arpana established a centre in Himachal Pradesh where similar facilities and services are being offered.

All this, as Omvati says, has been realized because of a group of people and their devotional offering, Arpana, which has literally brought health, wealth and happiness to thousands of lives. ■

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In the next issue

"Target 2000 – A world without polio" is the slogan and theme for World Health Day on 7 April 1995. The next issue of ***World Health*** will mark this event, describing the worldwide effort to free humanity of this crippling disease. Poliomyelitis still exists in different parts of the world, but no new cases have been recorded in the Americas since August 1991. ■

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